Request for Class Deviations From the FAR
For
TRICARE Next Generation Managed Care Support Contracts

1. CONTRACTING AGENCY: Office of the Assistant Secretary of Defense for Health Affairs, TRICARE Management Activity (TMA), Acquisition Management & Support (AM&S), Aurora, Colorado.

2. PROPOSED DEVIATIONS: The TMA requests class deviations **only** for the cost-plus-incentive-fee (CPIF) portion of the acquisition for the TRICARE next generation Managed Care Support Contracts (MCSCs) from:

a. FAR 17.206(a), which requires that, in awarding the basic contract, the Contracting Officer shall evaluate offers for any option periods contained in the solicitation when it is likely that the Government will exercise the options;

b. FAR 15.404-1(d)(2), which requires a cost realism analyses performed on all cost-reimbursement contracts to determine the probable cost of performance for each offeror;

c. FAR 52.216-10(b)(1), Incentive Fee, a clause required by FAR 16.307(d) in solicitations and contracts when a cost-plus-incentive-fee contract is contemplated, which requires that target costs be "initially negotiated" without allowance for a negotiated pre-set contract formula to establish target costs in option years as a default when negotiations are unsuccessful.

e. FAR 52.216-7, Allowable Cost and Payment, a clause required by FAR 16.307 in solicitations and contracts when a cost-reimbursement contract (other than a facilities contract) is contemplated, which is deemed inapplicable and incompatible with the proposed TRICARE next generation MCSCs.

3. AUTHORITY: The Director of Defense Procurement, Office of the Under Secretary of Defense (Acquisition, Technology and Logistics) is the approval authority for class deviations under DFARS 201.404(b)(i). The proposed deviations meet the categorizations found in FAR 1.401(a) regarding acquisition actions inconsistent with the FAR.

4. DESCRIPTION OF DEVIATIONS:

a. The proposed deviation from FAR 17.206(a) would permit the Contracting Officer to award the basic contract without an evaluation of health care costs for all option periods although it is likely that the Government will exercise all options. Under the proposed deviation, award of the TRICARE contracts would be made, consistent with

authority under 10 USC 1073a, on the basis of "best value to the United States **to the maximum extent consistent with furnishing high-quality health care in a manner that protects the fiscal and other interests of the United States**." (Emphasis added) To protect the fiscal and other interests of the Government, it is proposed that the Source Selection Authority only consider the evaluated target health care costs for the initial 12-month option period for the cost-plus-incentive-fee (CPIF) portion of the contracts. As detailed below, the best value analysis shall also include evaluation of all other contract costs and profit as part of the administrative fixed prices offered for all contract option periods as well as the proposed CPIF underwriting (target) fee for all option periods.

b. The proposed deviation from FAR 15.404-1(d)(2) would permit award of contracts without an evaluation of the probable health care costs of performance under the CPIF portion of the contract for each offeror for all option periods. As detailed below, a cost realism analysis would include an evaluation of the probable health care costs of performance under the CPIF portion of the contract for each offeror for only the first 12-month option period.

c. The proposed deviation from FAR 52.216-10(b)(1) would permit use of a default contract pre-set formula to determine the health care target costs in option years 2 through 5 in the event the parties are unable to reach a negotiated agreement as to the target cost for a given option year. As detailed below, it is our intent that the target health care costs for all periods after the first option period will be negotiated prior to exercise of each option. In the event that the parties cannot agree upon a target cost for a given option period, however, the target cost will be determined by a pre-set formula specified in the contract.

d. The proposed deviation from FAR 52.216.7 includes:

1) Redrafting FAR 52.216-7(a)(1) to change the frequency of payments from once every 2 weeks to every Government business day **and** to delete FAR 52.216.7(a)(3) on interim financing payments as unnecessary in view of the authorized frequency of payments;

2) Redrafting (b) *Reimbursing Costs* to accurately reflect the reimbursement methods under this contract and including specific definitions for "allowable costs" unique to this contract;

3) Deleting (c) *Small Business Concerns* as not applicable to the CPIF contract;

4) Deleting (d) *Final Indirect Cost Rates* as not applicable to the CPIF contract;

5) Deleting (e) *Billing Rates* as not applicable to the CPIF contract;

6) Deleting (f) *Quick-closeout procedures* as not applicable to the CPIF contract;

7) Redrafting (g) *Audits* to include a definition of audits applicable to the CPIF contract;

8) Deleting the provision in (h) *Final Payment* (2) regarding reasonable expenses incurred by the Contractor for securing refunds, rebates, credits, or other amounts as not applicable to the CPIF contract.

5. SIGNIFICANT EFFECTS: The deviations will not have a significant cost or administrative impact on contractors or offerors. The deviation will simplify the administrative process by which offerors will draft cost proposals under the CPIF portion of the solicitation. The only deviation that impacts the administration phase of the acquisition is the deviation from FAR 52.216.7. That deviation will result in an acquisition clause which is specifically tailored to the unique aspects of the TRICARE next generation of Managed Care Support Contracts. It is anticipated by TMA that the deviation will lower the costs of administration for the contractor. The deviation will clearly define allowable costs under the CPIF portion of the contract consistent with the contract methodology adopted to comply with statutory requirements for contractor financial underwriting of the delivery of health care. Reimbursing the direct health care costs is simplified by deleting some of the requirements in FAR 52.216-7 which are inapplicable to the financial underwriting conditions of this contract. Payments to the contractor will be expedited by altering the FAR clause thereby reducing costs incurred by the contractor resulting from delayed reimbursement of applicable health care costs. The deletion of the provision for allowable cost for securing refunds, rebates and credits or other amounts is appropriate since all such costs will be included in the contractors' prices for administrative services under the fixed-price (requirements) administration portion of the contracts.

6. TIME PERIOD: The requested time period for the FAR deviations will be for the duration of the acquisition of the TRICARE next generation of Managed Care Support Contracts. TMA intends to award these contracts for a basic start-up contract, with 5 option periods of 12-months each for the delivery of health care.

7. PREVIOUS DEVIATIONS: These FAR deviations have not previously been requested or approved for TMA acquisitions.

8. FEDERAL REGISTER PUBLICATION: The proposed deviations have not been published in the Federal Register; therefore, TMA is not providing an analysis of the Federal Register comments.

9. REVIEW OF LEGAL COUNSEL: [redacted] Redacted

10. RATIONALE FOR REQUEST: The deviations recognize the unique nature of TRICARE acquisitions under which contractors are required to financially underwrite the delivery of health care for an unenrolled beneficiary population under a statutory entitlement program and under which the contractors are required to deliver health care through civilian health care providers only when such health care is not otherwise determined to be available through military health care facilities. This type of contract is not consistent with commercial type health care plans or insurance and is not compatible with all policies, procedures,

solicitation provisions, contract clauses, methods, or practices of conducting acquisition actions as prescribed by the FAR.

Previous acquisitions of TRICARE Managed Care Support Contracts (MCSCs) have proven difficult and complex to award and administer. The TRICARE next generation of MCSCs attempts to address problems experienced under the initial MCSC acquisitions in developing simplified and cost-effective acquisitions. The requested deviations support this effort.

BACKGROUND:

Prior Generations of TRICARE MCSC. Commencing in 1993, 7 TRICARE MCSCs were awarded for 12 geographical regions within the continental United States. As solicited and awarded, the contracts were for a basic start-up contract, with 5 option periods of 12-months each for delivery of health care. The current contracts are fixed price for all administrative services and health care costs; however, the fixed price for health care costs is subject to redetermination through a complex process known as the Bid Price Adjustment (BPA), with a risk sharing formula under which the contractors and the government share increased costs or savings. The purpose of the BPA is an attempt to adjust for numerous factors impacting health care costs not otherwise within the control of the contractor; e.g., fluctuations in the number of beneficiaries receiving health care in military treatment facilities (MTFs). Generally, the more care provided in MTFs, the less care that the contractor must provide, and *vice versa*.

The intent of the BPA process and risk sharing was to mitigate the risks inherent in financially underwriting the delivery of health care. Simply put, there are an extraordinary number of variables which may affect health care costs in the contract option periods that cannot reasonably be forecasted at the time of proposal preparation. During the 5-year time period covered by the options, extraordinary and unforeseen changes in health care may (and do) occur. Therapies that were highly experimental (or non-existent) when bids were proposed might become the standard of care during the life of the contract. Expensive technology and medications may become available for chronic and common conditions. As a result, it has proven unreasonable to pursue TRICARE contracts with a fixed price for health care costs, even with a BPA process.

In addition, the BPA process required compilation of complex data detailing the interaction of the MTFs and contractor health care delivery systems. This data was not always available in a timely, comprehensive, and credible manner, leading to delays in BPA resolution and disputes with the contractors.

The fixed price nature of the contracts also resulted in unduly complicated problems with change orders. The continual changes in TRICARE statutory entitlements due to congressional mandates significantly contributes to the change order dilemma. Adding health care benefits and delivery process changes to the contracts through negotiated change orders has become problematic, due substantially to the difficulty of projecting the resulting health care costs for future option periods. This in turn leads to significant backlogs in

negotiating change orders and other requests for equitable adjustments; all of which contribute to the lack of predictability and stability in DoD's annual health care budget.

Next Generation of MCSCs. Instead of a fixed price contract subject to redetermination through the BPA, TMA intends an award that will combine contract types. The basic contract period will involve a start-up period during which the contractor will establish, staff, and test all administrative systems necessary to deliver, in coordination with MTFs, and pay for health care authorized for eligible beneficiaries under the statutory entitlement program. The contract will include 5 option periods of 12-months each during which health care will actually be delivered to, and paid on behalf of, eligible beneficiaries. In recognition of the need for stability in administration of the statutory entitlement program, avoidance of unnecessary disruption in health care provider and patient relations, and the high cost in terms of money and other resources for contract start-up experienced by both the contractor and Government, it is the present intent of the Contracting Officer to exercise all options under the next generation MCSC.

Health care costs will be provided under a CPIF type arrangement under which the only allowable costs will be defined as those direct payments for health care which pass TRICARE Encounter Data (TED) edits for health care a) furnished to eligible TRICARE beneficiaries, b) authorized as covered benefits, c) furnished by authorized TRICARE providers, and d) paid in conformance with TRICARE reimbursement methodologies. Government-approved resource sharing expenditures (in which the contractor supplies a health care provider or other health care asset to a military health care facility) will also be allowed health care costs. Except for the underwriting fee under the CPIF arrangement, all other contractor costs and profit will be paid under the fixed-prices (requirements) with incentive and award fees resulting from the competitively negotiated contract awards.

Under the CPIF portion of the contract, offerors will propose a target cost for health care **only** for the first option period of performance but will propose an underwriting (target) fee for every option period. The actual underwriting fee received for each option period will be adjusted (subject to positive and negative caps) by a formula based on the relationship of total allowable health care costs to total target health care costs. The underwriting fee has a potential to be negative -- i.e., if health care costs overrun the target costs by a large enough amount, the contractor will not only receive no underwriting fee but will lose equity put at risk under the contract. This approach is consistent with the statutory mandate for "financial underwriting" by TRICARE contractors.

The target health care cost for the first option year will be established through the competitively negotiated offers in response to the RFP. It is our intent that the target health care costs for all periods after the first option period will be negotiated prior to the exercise of each option. The underwriting fee for each option period will be fixed at initial award based on the competitive offers in response to the RFP. In the event the contractor and the Government cannot agree upon a target cost for a given option period, the target cost will be determined by a pre-set formula specified in the contract. That formula envisions a national TRICARE cost trend factor [based on the allowable TRICARE health care costs incurred by the Government for all geographical regions within the continental United States (including

the contractor's specific region) during the 12-month period of the option being exercised compared to the national allowable TRICARE health care costs incurred during the previous 12 month option period] multiplied by the contractor's allowable health care costs for the contract period immediately prior to the period for which the option is being exercised. Because the formula includes the allowable TRICARE national health care costs incurred during the period of the option being exercised, the formula will be applied at the end of that option period to establish the target cost retroactively to the beginning of the option period.

This approach is an attempt to create an analogous situation with how commercial health plans/insurers price their health care business. Given the highly volatile and unpredictable nature of health care costs over the long term, commercial plans base their annual premiums on the actual costs of health care incurred in the year immediately preceding the next policy year. Therefore, commercial plans attempt to predict the costs of health care only for the next 12-month period and adjust their premiums accordingly. The TRICARE next generation of MCSCs will adapt this annual cost re-basing into the CPIF portion of the contract in order to make our cost realism analysis practicable and meaningful. Although the TRICARE method of annual rebasing will generally be achieved through negotiation of the target health care costs for the option period prior to execution of the option, we envision rare occasions when the default formula will result in deferring establishment of the target health care costs from the outset of the option period until the end of the option period -- with application retroactively to the beginning of the option period.

ANALYSIS OF DEVIATIONS:

Deviations from FAR 17.206(a) and FAR 15.404-1(d)(2)

Under existing GAO case law and FAR 15.404-1(d)(2), the Government is obligated, during the evaluation of proposals on a cost-reimbursement contract, to undertake a cost realism analysis to determine the probable cost of performance of each offeror. The cost realism analyses undertaken in the first round of MCSC acquisitions was at the heart of nearly every protest filed at GAO on each MCSC. In the first MCSC (TRICARE Regions 9, 10 & 12), GAO ruled that the agency failed to conduct a proper cost realism analysis. In the next MCSC award (TRICARE Region 11) GAO upheld the agency award, specifically reviewing and approving a revised cost realism analysis. Subsequently, however, a nearly identical cost realism analysis scheme was viewed as "mechanical" in a GAO reconsideration decision sustaining a protest involving the MCSC award for TRICARE Regions 2/5.

Clearly, the cost realism analyses undertaken by TMA with regard to the MCSC procurements have caused GAO some concern. We believe that this concern arises, to a substantial degree, from the very unique and complex nature of the type of costs that are being estimated. Generally, cost realism analysis in cost reimbursement acquisitions focus on labor and attendant costs. These costs are fairly quantifiable--e.g., there is general consensus over what engineers may cost, and general agreement over the types of costs that make up indirect rates. By contrast, MCSCs deal with health care -- a much more nebulous area.

As noted, all contractor and subcontractor costs (other than health care costs) for performance of the contract will be included in the fixed price (requirements) portion of the contract. The CPIF portion of this contract will only include the healthcare costs allowable under specific terms of the contract. These health care costs are much less subject to contractor control than labor and related costs under the typical cost reimbursement contract. The contractor's ability to control health care costs is limited in several significant ways:

1. TRICARE is an entitlement program--any person meeting statutory eligibility is entitled to receive authorized health care. Many factors uncontrollable by the contractor or Government influence a beneficiary's decision to access health care under TRICARE. For example, there are hundreds of thousands of eligible beneficiaries who may choose not to use such benefits due to health care benefits available through their employment or the employment of their spouse. [Unlike commercial health plans, TRICARE is almost always a secondary payer for beneficiaries covered by another health plan.] Changes in the economy may lead to layoffs or reduced health care benefits for those still employed. This in turn may lead to substantial changes in the number of beneficiaries using the TRICARE system, along with attendant health care costs.

2. Over two-thirds of all health care provided to TRICARE-eligible beneficiaries is provided in the MTFs. The availability of health care in MTFs may change dramatically during future contract option periods. MTFs and bases may close or military providers of health care may be deployed in support of military operations, substantially shifting the workload and costs for delivering health care to the contractor. In addition, thousands of reservists may be called to active duty due to a national emergency, significantly increasing the number of family members eligible for the statutory health care entitlement. These, and other similar situations, will impact health care costs.

3. One of the critical ways in which contractors manage health care costs is through the amounts they pay their network providers. These arrangements generally reflect a discount from the ceiling price set by law, the TRICARE Maximum Allowable Charge (TMAC). These discounts are almost invariably negotiated on a yearly basis -- i.e., the rates set are guaranteed for only one year. Therefore, it is very difficult to project what network providers will be paid more than one year at a time.

4. High cost technology, therapies or medications which are non-existent or considered unproven when offers are requested may become the standard of care, with attendant health care costs, for thousands of beneficiaries over the course of a contract with 5 one-year option periods.

As a result, the ability of the contractor (or the Government) to project health care costs for all option periods is very problematic. TMA believes that the ability of cost realism evaluators to project health care costs over five option years is so limited, given all the attendant variables, that any projected probable costs would be impracticable and subject to great uncertainty. Therefore, it makes little or no sense to require the government to undertake a cost realism analysis for health care costs for all option years of the contract.

By contrast, the Government has a reasonable belief in its ability to analyze proposed health care costs for the first option year of performance. This is due to several factors. First, provider discounts are almost always negotiated yearly. Therefore, the Government can reasonably analyze proposed discount rates for the first option year and compare them among offerors. Additionally, a one-year period limits the degree to which changes in the direct care system, changes in enrollee population, and development of unanticipated therapies/medications may impact healthcare costs. Finally, as previously noted, the process will be comparable to pricing of commercial health care plans in recognition of the exceptionally dynamic health care environment.

Such action, however, would be inconsistent with the FAR clauses for which deviations are requested. The proposed cost realism analysis would, as noted, not estimate the probable health care costs of performance for all offerors during the life of the contract. We believe that the availability of health care underwriting (target) fees and the health care target costs for the first option period will enable TMA to do a cost realism analysis of all probable costs of performance over which the contractor and the Government have some predictability at the time competitive offers are submitted. Predicting, at the time of proposal submission, the health care costs for option periods 2 through 5 that depend primarily on the volatile nature of a health care entitlement program subjects any evaluation to a high degree of uncertainty. Failure to do so, however, imposes a degree of risk and jeopardy to the agency for technical non-compliance with the FAR requirement. Therefore, TMA seeks a deviation from FAR 17.206(a) and FAR 15.404-1(d) to exclude health care target costs for option periods 2 through 5 from evaluation of offers for those option periods and from the requirement for a cost realism analysis to determine the probable cost of performance for each offeror.

Deviations from FAR 52.216-10(b)(1)

As previously noted, the target health care cost for the first option year will be established through the competitively negotiated offers in response to the RFP. It is our intent that the target health care costs for all periods after the first option period will be negotiated prior to the exercise of each option. The underwriting fee for each option period will be fixed at initial award based on the competitive offers in response to the RFP.

TMA believes that negotiation of the health care target cost on a yearly basis will address much of the previously described uncertainty inherent in predicting long-term health care costs that have plagued the current MCSCs. However, the need for continuity of contract performance for the uninterrupted delivery of a statutory health care entitlement requires a contract solution should the parties not reach agreement as to a target health care cost for a given option year after good-faith negotiations. In the absence of some form of a contract default mechanism for establishing a target cost, the contracting officer could be in an untenable position; accepting a target cost which may not be determined to be fair and reasonable or not exercising a contract option period, with the resultant overwhelming disruption of an entitlement program for millions of beneficiaries.

The default mechanism under the proposed contract will be a formula, as described above, to set the target cost. The following provides an example of how the formula is intended to function:

> Assume that the contractor and the Government were unable to agree, 30 days prior to end of an option period 1 (OP1), to a target cost for Option Period 2 (OP2). The pre-set contract formula would establish the target cost for OP2 equal to that contractor's allowable health care costs in OP1 multiplied by the TRICARE national trend in allowable health care costs from OP1 to OP2. (This would be the combined trend of health care costs from all three TRICARE MCSCs.) This adjustment will be calculated retroactively (i.e., after the end of OP2 in this example) to allow measurement of the national trend from one contract year (OP1) to the next (OP2). Thus, if the costs in the particular region for OP1 were equal to $725 million and the TRICARE national trend in allowable health care costs from OP1 to OP2 was 10 percent (measured from allowed healthcare costs for all 3 TRICARE MCSCs), then the adjusted target cost for OP2 for this contract would be $797.5 million.

The TRICARE national trend in allowable health care costs from the previous year to the current year will reflect the impact of current national MTF workload trends and trends in allowable health care costs in general, including the impact of change orders implemented in all 3 TRICARE MCSCs. Thus, this mechanism implicitly incorporates the three factors that are likely to have the largest effect on trends in allowable health care costs from one year to the next -- trends in MTF delivery of care, national trends in health care (e.g., medical care inflation, introduction of high cost technology or medication, etc), and benefit changes in the entitlement program -- because the impact of all three will be reflected in the national cost trend. As a result, TMA believes that the proposed mechanism will provide a fair and reasonable target health care cost for a given contract region, in the event that the parties are unable to negotiate a target cost for a given option period.

Therefore, TMA requests a deviation from FAR clause 52.216-10(b)(1), to read as follows: (additions underscored)

> (1)..."Target cost," as used in this contract, means the estimated <u>health care</u> cost of this contract as initially <u>or subsequently</u> negotiated, <u>or as otherwise determinable by applying a formula contained in the basic contract</u>....

TMA notes that the proposed concept is consistent with FAR 16.405-1(b), which indicates that CPIF contracts shall specify a target cost. The proposed contract does indeed "specify a target cost," either through bilateral negotiations or use of the formula, as described above, to be incorporated in the basic contract.

Although the formula results in applying a national trend factor to the contractor's allowable costs for the previous option year in establishing the target cost for the next option period, TMA does not believe the formula violates the prohibition against a cost-plus-percentage-of-cost system of contracting under FAR 16.102(c) because, among other matters, the contractor's underwriting fee for the option period would not be based on a percentage of the contractor's actual costs for that option period.

TMA believes that the unique nature of TRICARE acquisitions again supports the appropriateness of this deviation. The TRICARE environment makes such a retroactive fallback formula necessary to accommodate unpredictability during the option period exercised related to levels of military health care facility workload (due to deployments of providers of health care for military operations or contingencies), the unpredictability of mandated benefit changes throughout the option year under a statutory entitlements program (as opposed to the commercial practice of maintaining a stable benefit package during the current year covered by established premiums), and the unpredictable changes in TRICARE health care delivery and costs (frequently due to advances in high cost technologies, therapies, and pharmaceuticals). This risk mitigation should produce better value for the Government by reducing the risk premium offerors would propose in their underwriting (target) fees. TMA anticipates that the intended negotiation process will also be more successful in achieving a prospective target health care cost if neither party knows (during the negotiation process) the value of the default target that would apply if agreement is not reached through negotiation.

Deviations from FAR 52.216.7

The Government requests that each of the following deviations from FAR 52.216-7 be approved and that the redrafted clause at TAB A be approved.

1. The frequency of payments should be changed from not more than once every 2 weeks (FAR 52.216-7(a)) to every business day. This will decrease the financial burden upon the contractor. Each contractor will pay out an enormous amount of health care costs on a daily basis. The Government wishes to avoid paying any additional costs for interest that would occur if the payments to the contractor were not immediately reimbursed. More importantly, it is in the best interest of the government to avoid any disruption of health care to eligible beneficiaries. Increasing the frequency of the payments to the contractor will facilitate prompt payments to health care providers. This in turn will avoid the potential denial of timely access to health care services that could occur if health care providers suffer delayed cash flow in their business operations.

In addition, the phrase "in accordance with Federal Acquisition Regulation (FAR) subpart 31.2 in effect on the date of this contract" should be deleted from this paragraph. Since only health care costs are "allowable costs" under the CPIF portion of this contract, many of the provisions of FAR 31.2 relating to allowable costs are inapplicable.

2. The provision in FAR 52.216-7(a)(3) for interim contract financing payments is unnecessary in view of the available daily payments and should be deleted.

3. The provision in FAR 52.216-7(b) for Reimbursing Costs must be changed to correspond with the limited allowable costs intended under the CPIF portion of the contract. TMA intends to delete many portions of FAR 52.216-7(b) and to redraft some of the remaining portions. (See attached redrafted clause.) The following comments are provided on the proposed redraft of FAR 52.216-7(b):

(b) *Reimbursing costs.* (1) For the purpose of reimbursing allowable costs, the term "costs" includes only those direct health care costs submitted on vouchers that, at the time of the request for reimbursement have passed the initial TED edits, fully or provisionally, as well as Government-approved resource sharing expenditures, and that the Contractor has actually paid by check, electronic funds transfer, or other form of actual payment for health care under the contract. The costs eligible for reimbursement are the health care costs which pass TED edits involving health care furnished to an eligible beneficiary, health care authorized under TRICARE, health care furnished by an authorized TRICARE provider, and health care costs consistent with authorized TRICARE reimbursement methodologies, as well as Government-approved resource sharing expenditures. Costs reimbursed based on vouchers passing initial TED edits and resource sharing costs are subject to further audit and adjustments made for overpayments by the Government if determined not to qualify as an allowable cost. The Government's right to audit and recover costs determined not to be allowable health care costs is in addition to all rights under the Inspection of Services clause (FAR 52.246-5).

The unique nature of this contract requires the Government to create a unique definition of "allowable costs" under the CPIF portion of the contract. The solicitation defines "allowable cost" as health care costs that pass the TRICARE Encounter Data ("TED") edits and Government-approved resource sharing expenditures. Health Care Costs are defined as direct health care costs that are underwritten by the contractor. The Government will be allowing only actual health care costs and the underwriting (target) fee to be reimbursed under the CPIF portion of the contract. All other costs or expenses incurred in contract performance, including direct/indirect costs and profits under the contract shall be included in the administrative fixed-price portion of the contract. Once the contractor adjudicates and pays a health care claim and submits the appropriate documentation for TED edits, this will be deemed an acceptable invoice or voucher as required by FAR 52.216-7(a)(1) and the Government will reimburse the contractor on a daily basis for the adjudicated health care costs.

4. The Government proposes to delete FAR 52.216-7(c) *Small Business Concerns.* This provision of the FAR provides that small business concerns may receive more frequent payments than every 2 weeks. This clause is unnecessary since the Government anticipates making payments to the contractor every business day.

5. The Government proposes to delete FAR 52.216-7(d) *Final Indirect Cost Rates*. This provision is inapplicable to this acquisition. The Government is only required to reimburse the Contractor for the actual health care costs that pass the TED edits under the CPIF portion of the contract and no indirect costs are allowable under the terms of the CPIF portion of the contract. The Offeror must bid all its indirect costs under the administrative fixed-price (requirements) portion of the contract.

6. The Government proposes to delete FAR 52.216-7(e) *Billing rates.* This provision of the FAR is inapplicable to this acquisition. The billing rates are established to allow the Government to reimburse the contractor before the final annual indirect cost rates are established. Since all indirect cost rates will be proposed under the administrative fixed-price (requirements) portion of the contract, there will not be any need for the Government to establish billing rates in order to reimburse the Contractor under the CPIF portion of the contract. The Contractor will be reimbursed under the cost portion of the contract based upon actual health care costs that pass the TED edits.

7. The Government proposes to delete FAR 52.216-7(f) *Quick-closeout procedures.* This provision of the FAR is inapplicable to this acquisition. The Quick-closeout procedures are in FAR 42.708 and are applicable to indirect cost rates. Since there will not be any indirect costs applicable to the CPIF portion of this contract, the inclusion of the Quick-closeout procedures in this contract is unnecessary.

8. The Government proposes to modify FAR 52.216(g) *Audits* to include the following definition: "'Audits' as used in this clause, includes audits on statistically valid samples. The audit results will be extrapolated across all the TRICARE medical claims for the region submitted for TED edits during the audited period to determine total unallowable costs of the population sampled, or will be used to determine the total overpayment or underpayment of the TRICARE medical claims population sampled for the region. The results of the audits will be used to adjust for overpayments and underpayments of health care costs provisionally paid following TED edits. These adjustments are in addition to the Government's rights under the Inspection of Services Clause (FAR 52.246-5)." The Government audits statistically valid samples of medical care claims to determine if the claims were appropriately paid. The results of the audits on the statistically valid samples are applied to the total TRICARE medical claims population for the region. This modification will clarify that the government does not audit each medical care claim, but applies the results of the audit of a statistically valid sample to all the medical care claims for the audited period.

9. The Government proposes to delete, in FAR 52.216-7(h)(1), the language "in accordance with paragraph (d)(4) of this clause." The phrase must be deleted since there is no longer paragraph (d)(4) in the solicitation.

10. The Government proposes to delete a portion of FAR 52.216-7(h)(2) *Final Payment.* The Government proposes to delete the sentence, "Reasonable expenses incurred by the Contractor for securing refunds, rebates, credits, or other amounts shall be allowable costs if approved by the Contracting Officer." The acquisition requires that all direct/indirect costs and profit for performance of the contract be proposed under the fixed-price portion of the solicitation. Health care costs that pass the TED edits, government-approved resource sharing costs, and the underwriting fee will be the only payments made under the CPIF portion of the contract. The Contractor will not be allowed to seek reimbursement under both the administrative fixed-price portion of the contract and the CPIF portion of the contract.

TAB A

PROPOSED DRAFT OF REPLACEMENT CLAUSE FOR FAR 52.216-7

ALLOWABLE HEALTH CARE COST AND PAYMENT

(a) *Invoicing.* (1) The Government will make payments to the Contractor when requested as frequently as every Government business day, in amounts determined to be allowable in accordance with the terms of this contract. The submission of health care costs that pass the TED edits will be considered an invoice for reimbursement of health care costs. A contractor invoice for approved resource sharing expenditures will also be reimbursed as an allowable cost.

(2) Contract financing payments are not subject to the interest penalty provisions of the Prompt Payment Act. Interim payments made prior to the final payment under the contract are contract financing payments, except interim payments if this contract contains Alternate I to the clause at 52.232-25.

In the event that the Government requires an audit or other review of a specific payment request to ensure compliance with the terms and conditions of the contract, the designated payment office is not compelled to make payment by the specified due date.

(b) *Reimbursing costs.* For the purpose of reimbursing allowable costs, the term "costs" includes only those --

(1) submitted on vouchers either for direct health care costs that, at the time the request for reimbursement has passed the TED edits, fully or provisionally, or for Government-approved resource sharing expenditures; **and**,

(2) that the Contractor has actually paid the costs or made the expenditures by issuing a check, electronic fund transfer, or other form of actual payment for health care under this contract.

The costs eligible for reimbursement are the health care costs that pass TED edits involving health care furnished to an eligible beneficiary, health care authorized under TRICARE, health care furnished by an authorized TRICARE provider, and health care costs consistent with authorized TRICARE reimbursement methodologies, as well as Government-approved resource sharing expenditures. Costs reimbursed based on vouchers passing initial TED edits and vouchers for resource sharing costs are subject to further audit and payment adjustment by the Government if determined not to qualify as an allowable cost. The Government's right to audit and recover costs determined not to be allowable health care costs is in addition to all rights under the Inspection of Services clause (FAR 52.246-5).

(d) *Audit.* At any time or times before final payment, the contracting Officer may have the Contractor's invoices or vouchers and statements of cost audited. "Audits" as used in this clause, includes audits on statistically valid samples. The audit results will be extrapolated across all the TRICARE medical claims for the region submitted for TED edits during the audited period to determine the total overpayment or underpayment of the TRICARE medical claims population sampled for the region. The results of the audits will be used to adjust for overpayments and underpayments of health care costs. These adjustments are in addition to the Government's rights under the Inspection of Services Clause (FAR 52.246-5). Any payment may be--

(1) Reduced by amounts found by the Contracting Officer not to constitute allowable costs; or

(2) Adjusted for prior overpayments or underpayments.

(e) *Final Payment.* (1) Upon approval of a completion voucher submitted by the Contractor, and upon the Contractor's compliance with all terms of this contract, the Government shall promptly pay any balance of allowable costs and that part of the fee (if any) not previously paid.

(2) The Contractor shall pay to the government any refunds, rebates, credits, or other amounts (including interest, if any) accruing to or received by the contractor or any assignee under this contract, to the extent that those amounts are properly allocable to costs for which the Contractor has been reimbursed by the Government. Before final payment under this contract, the Contractor and each assignee whose assignment is in effect at the time of final payment shall execute and deliver--

(i) An assignment to the Government, in form and substance satisfactory to the Contracting Officer, of refunds, rebates, credits, or other amounts (including interest, if any) properly allocable to costs for which the Contractor has been reimbursed by the Government under this contract; and

(ii) A release discharging the Government, its officers, agents, and employees from all liabilities, obligations, and claims arising out of or under this contract, except--

(A) Specified claims stated in exact amounts, or in estimated amounts when the exact amounts are not known;

(B) Claims (including reasonable incidental expenses) based upon liabilities of the Contractor to third parties arising out of the performance of this contract; provided, that the claims are not known to the contractor on the date of the execution of the release, and that the Contractor gives notice of the claims in writing to the Contracting Officer within 6 years following the release date or notice of final payment date, whichever is earlier.

Signature Page

Signatures filed with original copy